Foot & Ankle Specialists of Marysville

Carly Robbins, DPM, FACFAS | Nicklaus Bechtol, DPM, FACFAS

388 Damascus Rd. | Marysville, OH 43040 | p: 937.578.4021 | f: 937.578.4011

marysvillefootdoctors.com

Patient Information

Last Name: _____ First Name: _____ M.I: _____

D.O.B._____ SSN#_____Gender: M F

Address: _____City: _____ Zip: _____

Home#_____ Cell #_____

E-Mail Address: _____

If Minor, list parent's names: _____

Parent's SS #_____

Emergency Contact:_____ Phone #_____

Pharmacy_____ Phone #_____

Race: Caucasian African American Asian Other: _____

Please circle one: Non-Hispanic or Latino OR Hispanic or Latino

Marital Status: Married Single Widowed Separated Divorced

Family Doctor: _____

Insurance Information

Primary Insurance Company_____

Subscriber's Name _____SSN#_____ D.O.B._____

Secondary Insurance Company_____

Subscriber's Name _____SSN#_____ D.O.B._____

Employment Information

Patient's Employer_____

Address_____City_____Phone#_____

Occupation_____

Circle One: Full-Time Part-Time Self-Employed Un-Employed Retired Military

Acknowledge of Receipt HIPAA of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose), or declined a copy and understand the Notice.

_____ _____

Patient Name (Please Print) Patient Signature

_____ _____

Parent or Authorized Representative Date

Personal Representative: _____

Description of Personal Representatives Authority: _____

Name person(s) we may discuss your medical information with: _____

(This form does not constitute legal advice. This form is based on current federal Law and subject to change based on changes in Federal Law or subsequent interpretive guidance. This dorm is based on Federal Law and must be modified to reflect State Law where that State Law is more stringent than the Federal Law or other State Law exceptions only).

Signature on File

The undersigned hereby authorizes the release of any medical information necessary to process insurance claims as may be payable to the undersigned under any contract of insurance with respect to services rendered by Dr. Carly Robbins/Dr. Nicklaus Bechtol. If assignment is accepted, I authorize direct payment to Dr. Carly Robbins/Dr. Nicklaus Bechtol. The undersigned hereby agrees to be financially responsible for any charges not covered by the insurance company.

_____ _____

Patient Signature Date

Consent for Communication of Protected Health Information (PHI) Via Unsecure Transmissions

I, _____, hereby consent and authorize Foot & Ankle Specialists of Marysville to communicate my PHI through the following unsecure transmissions:

O Cell Phone (which includes text messaging and voice mails)

O Email

O I do not wish to have my protected health information transmitted electronically

In regards to messages left on voicemail or an answering machine, you authorize your doctor or staff (please choose one):

O To leave messages regarding your medical condition(s), as well as appointment reminders, billing/ financial questions, and requests to call the office.

O To leave only messages regarding appointment reminders and requests to call the office. Do not reference your medical condition(s) in the message.

O Do not leave a message.

How did you hear about our office? Circle One

Family Doctor Insurance Directory Yellow Pages White Pages Internet Our Web Site Other:

_____

Patient Name: _____Date:_____

Medical History:

Age: _____ Height: _____ Weight: _____Shoe Size: _____

Allergies/Reaction: _____

_____

Medications:_____

_____

_____

Surgeries:_____

_____

_____

Family History: Diabetes Heart Problems Cancer

If Yes,
Who_____

Do you drink alcohol? Y N Do you use street drugs? Y N

Do you use tobacco products? Y N Have you ever used tobacco? Y N

Are you pregnant? Y N

* Have you had a Flu vaccine? Y N Date_____

* Have you had a Pneumonia Vaccine? Y N Date_____

Chief Complaint

Detailed explanation of your reason for today's visit

_____

_____

_____

_____

Where is your pain? _____

When did the condition start? _____

On a scale of 1-10(10 being worst), what is your pain level? _____

Describe your Pain (i.e. Sharp, Shooting, Dull, Tingling) _____

Have you tried anything to relieve the pain? (i.e. OTC meds, RX meds, Ice, Heat)

_____Did it help? Y N

Have you received treatment somewhere else for this problem? If yes, where?

_____

Patient Name: _____Date:_____

Please check any conditions that you've had in the past or currently have in the present.

Past	Present		Past	Present	
O	O	General Fatigue	O	O	Mental Status Changes
O	O	Abnormal Weight Gain/Loss	O	O	Depression
O	O	Eye Problems	O	O	Anxiety
O	O	Hearing Loss	O	O	Stroke
O	O	Speech Difficulty	O	O	Seizures
O	O	High Blood Pressure	O	O	Paralysis
O	O	High Cholesterol	O	O	Numbness
O	O	Heart Murmur	O	O	Dizziness
O	O	Chest Pain	O	O	Headache
O	O	Heart Attack	O	O	Diabetes Type_____
O	O	Leg Pain when walking	O	O	Hypothyroidism
O	O	Varicose Veins	O	O	Hyperthyroidism
O	O	Stents	O	O	Bleeding Disorder
O	O	Pace Maker	O	O	History of Blood Clots
O	O	Shortness of Breath	O	O	Coumadin/Blood Thinner
O	O	Asthma	O	O	Take Aspirin
O	O	Emphysema	O	O	Anemia
O	O	COPD	O	O	Deformed Nails
O	O	Acid Reflux	O	O	Ulcerations
O	O	Stomach Ulcers	O	O	Cancer_____
O	O	Liver Problems_____	O	O	Skin Disorders_____
O	O	Excessive Thirst/Hunger	O	O	Muscle Pain
O	O	Kidney Problems	O	O	Fractures
O	O	Incontinence	O	O	Sprains
O	O	Bursitis	O	O	Other_____
O	O	Arthritis_____			_____

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OFFICE POLICIES

- INSURANCE CARDS: Must be provided at every office visit.
- CO-PAYS: Co-pays must be paid upon arrival of your appointment.
- LATE APPOINTMENTS: If you arrive for your appointment more than 10 mins. late you maybe be asked to reschedule your appointment.
- NO SHOW/CANCELLATION: Failure to show up for a scheduled appointment is considered a NO SHOW. Patients who No Show two (2) or more times in a 12 month period, may be dismissed from the practice and will be denied any future appointments. Patients who No Show or do not provide 24 hours' notice to cancel an appointment may also be subject to a $25 fee. If you are a New Patient and NO SHOW for your first appointment you will not be rescheduled
- BALANCES: Patients will be asked to make a payment on their account prior to any scheduled appointments.
- RETURNED CHECK FEE: There is a returned check fee of $25.
- MEDICATION REFILL REQUESTS: Please allow up to 48 hours for all medication refills.
- TELEPHONE MESSAGES: Please allow up to 48 hours for a return phone call. If your call is a medical emergency please dial 911 or go to your nearest emergency room.
- FEES FOR FORMS: FMLA and Disability forms have a $20.00 fee for completion. Please allow up to 10 days for completion.
- NON-COMPLIANCE: Refusal or failure, in excess, to follow advice given by our providers may result in dismissal from our office. Patients will be notified and given 30 days to find a new provider. Patients will only be seen by our office in emergency situations during that period.

OFFICE HOURS:

Monday: 10:00am-5:00pm with lunch from 12:30pm-2:00pm

Tuesday: 9:00am-5:00pm with lunch from 12:30pm-2:00pm

Wednesday: 9:30am-4:00pm with lunch from 11:30am-1:00pm

Thursday: 9:30am-4:00pm with lunch from 11:30am-1:00pm

Friday: 8:30am-2:00pm